OF



C.L. BUTCH OTTER, GOVERNOR RICHARD M. ARMSTRONG - Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0036 PHONE 208-334-6626 FAX 208-364-1888

February 4, 2010

Doug Crabtree Eastern Idaho Regional Medical Center P.O. Box 2077 Idaho Falls, ID 83403-2077

RE: Eastern Idaho Regional Medical Center, provider #130018

Dear Mr. Crabtree:

This is to advise you of the findings of the complaint investigation, which was concluded at your facility on January 29, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies. The hospital is under no obligation to provide a plan of correction for Medicare deficiencies. If you do choose to submit a plan of correction, provide it in the spaces provided on the right side of each sheet.

Also enclosed is a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

An acceptable plan of correction (PoC) contains the following elements:

- · Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the POC is effective in bringing the hospital into compliance, and that the hospital remains in compliance with the regulatory requirements;

Doug Crabtree February 4, 2010 Page 2 of 2

- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

<u>Please sign and date both of the forms and return them to our office by February 17, 2010.</u> Keep a copy for your records. For your information, the Statement of Deficiencies is disclosable to the public under the disclosure of survey information provisions.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208) 334-6626.

Sincerely,

PATRICK HENDRICKSON

Health Facility Surveyor Non-Long Term Care SYLVIA CRESWELL

Co-Supervisor

Non-Long Term Care

PH/mlw

Enclosures

PRINTED: 02/02/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B WING _ 130018 01/29/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CHANNING WAY EASTERN IDAHO REGIONAL MEDICAL CENTER IDAHO FALLS, ID 83404 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY INITIAL COMMENTS A 000 A 000 This is the Plan of Correction from the self-report incident of 1/25/10. The following deficiencies were cited during the With regards to item A267, the complaint investigation of your hospital. The surveyors conducting the survey were: following corrective action plan hasoor will be implemented. Patrick Hendrickson, RN, Team Leader Staff will be provided with Aimee Hastriter, RN, HFS education regarding the need for thorough documentation of all Acronyms used in this report include: occurrences. This education has or will include the following: PI - Performance Improvement (a) Discussion at the BHC RN - Regestered Nurse Management Team meeting 2/3/10 of A 267 482.21(a)(2) QAPI QUALITY INDICATORS A 267 this recommendation from the exit interview. A follow-up review The hospital must measure, analyze, and track withithe 2/17/10 BHC Management quality indicators, including adverse patient Team after receiving the fdrmal events, and other aspects of performance that report. assess processes of care, hospital services and Preliminary education (b) operations. for staff about improved occurrence reporting during: This STANDARD is not met as evidenced by: *Hospital-wide staff meeting 2/3/10 Based on staff interview and review of patient records and PI records, it was determined the *Nursing staff meeting 2/11/10 hospital failed to ensure the PI program had *Teton Peaks staff meeting 2/8/10 analyzed all patient adverse events and injuries *Unit based council meetings 3/23/10 for 5 of 7 patients (#1, #2, #4, #5 and #6) whose records were reviewed. This resulted in the Formal education& reminders including: inability of the hospital to develop and implement *BHC Administration's monthly processes to improve care. The findings include: memo 2/26/10 *Inservice training for all 1. Patient #4 was a 34-year-old female who was direct care staff regarding admitted to the hospital on 8/12/09 for treatment documentation including Locdurrence of suicidal ideation and depression. reporting 3/31/10 The occurence reports Ongoing a. A Psychiatric Progress note, dated 8/26/09 at will be reviewed as they are 10:07 PM, stated Patient #4 was seen individually submitted by the Director of Nursing. following an attempted hanging in her room and These will be summarized & discussed subsequent transfer to the Adult Special Care each montheas the Nursing Start Mulg. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XGKZ11

Facility (D: IDLFQV

If continuation sheet Page 1 of 7

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PRINTED: 02/02/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED DENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C B. WING 130018 01/29/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CHANNING WAY EASTERN IDAHO REGIONAL MEDICAL CENTER IDAHO FALLS, ID 63404 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION (X4) ID EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 3. The Q.I. Dept. will A 267 A 267 Continued From page 1 help to set up a formal system Unit where she, again, attempted to tie a ligature to track & trend the occurrences. around her neck while in the bathroom. An Any identified trends will be Interdisciplinary Progress Note, dated 9/09/09 at addressed as they are identified. 3:15 PM, written by an RN stated, "Late entry for 8/26/09-approximally 12:40 PM." The note stated the RN opened a door and found the patient hanging from the top of a door. The patient was cared for and transferred to the Adult Special Care Unit. A second Interdisciplinary Progress Note, dated 8/26/09 at 1:25 PM, stated Patient #4 was in the bathroom in the safe area of the Adult Special Care Unit when the patient was found trying to hang herself with her bra. A Risk Occurrence Report, dated 8/31/09, documented only the first suicide attempt. No Risk Occurrence Report was found for the second sulcide attempt. On 1/27/10 starting at 4:10 PM, the Quality Director was Interviewed. He could not find a Risk Occurrence Report for the second suicide attempt for Patient #4. On 1/27/10 starting at 4:36 PM, the Executive Director of Risk Management and Physicians' Relations was interviewed. He also could not find a Risk Occurrence Report for the second suicide attempt for Patient #4. He stated that one should have been filled out for the second event. b. A nursing note, dated 8/27/09 at 5:37 PM, stated Patlent #4 was trying to scratch herself with a ring. A Psychiatric Technician Note, dated 8/27/09 at 6:10 PM, stated Patient #4 appeared to be using her rings to cut her arms and when her rings were taken away she began to "bang" her head on the floor. On 1/27/10 starting at 4:10 PM, the Quality Director was interviewed. He could not find a Risk Occurrence Report for the 8/27/09 event for Patient #4. On 1/27/10 starting at 4:36 PM, the Executive Director of Risk

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Event ID: XQKZ11

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and Physicians' Relations was interviewed. He also could not find a Risk Occurrence Report for the 8/31/09 event for Patient #4. He stated that one should have been filled out. He stated that reports should be filled out on all contraband found in the hospital's psychiatric center.

d. A physician's progress note, dated 9/13/09 at 12:39 AM, stated Patient #4 was given a medication that caused the patient to become agitated and thrash around as though she had severe akathisia (a syndrome characterized by unpleasant sensations of "inner" restlessness that manifests itself with an inability to sit still.) Patient

Department for evaluation. On 1/27/10 starting at

#4 was sent to the hospital's Emergency

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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| A 267 | Management and Finterviewed. He also Occurrence Report Patient #4. He state filled out. He state out on all self mutilic. A Psychiatric Te 4:30 PM, stated Pawith others when sto the bathroom. It hand clenched in a her hand and they broken into pieces. contraband Patient on the floor. A phy 9/01/09 at 10:50 Al Patient #4 secured for self-harm. On Quality Director was | Continued From page 2 Management and Physicians' Relations was interviewed. He also could not find a Risk Occurrence Report for the 8/27/09 event for Patient #4. He stated that one should have been filled out. He stated that reports should be filled out on all self mutilations. c. A Psychiatric Technician Note, dated 8/31/09 at 4:30 PM, stated Patient #4 was in the lounge area with others when she got up quickly and headed to the bathroom. It stated Patient #4 had her right hand clenched in a fist. Staff had Patient #4 open her hand and they found a pen lid that had been broken into pieces. When staff took away the contraband Patient #4 began to "bang" her head on the floor. A physician's progress note, dated 9/01/09 at 10:50 AM, stated that on 8/31/09, Patient #4 secured an object, a pen cap, to use for self-harm. On 1/27/10 starting at 4:10 PM, the Quality Director was interviewed. He could not find a Risk Occurrence Report for the 8/31/09 | | 57 | | | |

FORM CMS-2567(02-99) Právious Versions Obsolete

Event ID: XGKZ11

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| | He could not find a the 9/13/09 event for starting at 4:36 PM. Management and F interviewed. He also Occurrence Report Patient #4. He state filled out. He stated Report for medication be filled out. The hospital failed patient events related to the quality impro | ge 3 y Director was interviewed. Risk Occurrence Report for patient #4. On 1/27/10 the Executive Director of Risk Physicians Relations was to could not find a Risk for the 9/13/09 event for ed that one should have been at that a Risk Occurrence on adverse reactions should to ensure that all adverse ed to Patient #4 were reported vernent program so they could eps could be taken to prevent | A | 267 | | | |
| | admitted to the hos of suicidal ideation a. A Psychiatric Eve 10:23 PM, stated P | aluation, dated 1/14/010 at atlent #1 was allergic to the | | | | | |
| | and throat to swell. RN obtained a verb (intermuscular) as a medication order w given at 10:15 PM. PM, the Quality Diri could not find a Ris Patient #1 for the m | On 1/15/10 at 10:00 PM, a pai order for Geodon 20 mg IM a onetime dose. The as retracted before it was On 1/27/10 starting at 4:10 ector was interviewed. He k Occurrence Report for nedication event. On 1/27/10 the Executive Director of Risk; | | | | | |
| | Management and F interviewed. He also Occurrence Report stated that one sho | Physicians' Relations was so could not find a Risk for Patient #1 on 1/15/10. He uld have been filled out. He Docurrence Report for | | | | | ; |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FAX NO. 2082272369

P. 08
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| | medication near mi | sses should be filled out. | | , | | | · | |
| | stated Patient #1 at pressure tubing off He attempted to it t | ated 1/16/10 at 3:15 PM, tempted to take blood a blood pressure machine. ake them back to his room. | | | | | : | |
| : ! ! | PM, the Executive I understanding that pressure tubing in a | on 1/27/10 starting at 1:40 Director stated it was his Patient #1 took the blood attempt to cause trouble or 27/10 starting at 4:10 PM, the | | : | | | | |
| ; ; ; | Quality Director wa find a Risk Occurre the 1/16/10 event. | s interviewed. He could not noe Report for Patient #1 for on 1/27/10 starting at 4:36 | | | | | | |
| | and Physicians' Re also could not find a Patient #1 on 1/16/ | Director of Risk Management lations was interviewed. He a Risk Occurrence Report for 10. He stated that one should: | | • | | | : | |
| | have been filled out | to ensure that all adverse | | | | | | |
| : | events related to Pa quality improvemen | atient #1 were reported to the at program so they could be could be could be taken to prevent | | : | | | i ' ! | |
| | admitted to the hos of psychosis. A nui 10:21 PM, stated a | e 61-year-old male who was pital on 8/06/09 for treatment rsing note, dated 8/08/09 at Psychiatric Technician found patient's room. On 1/27/10 | | * | | | | |
| | starting at 4:36 PM Management and F interviewed. He co | the Executive Director of Risk Physicians' Relations was uld not find a Risk Occurrence 109 pocket knife and stated | | : | | | : | |
| | | to ensure that all adverse atient #6 were reported to the | | ; | | | | |

FORM CMS-2667(02-99) Previous Versions Obsolete

Event ID: XGKZ11

Facility ID: IDLEQV

If continuation sheet Page 5 of 7

DEPARTMENT OF HEALTH AND HUMAN SERVICES

P. 09

PRINTED: 02/02/2010 FORM APPROVED OMB NO. 0938-0391

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| | analyzed and steps further incidents. 4. Patient #5 was a admitted to the host depression and a standard in the host depression and a standard in the standard in the host attempted to strandard interview on 1/2 the Executive Dire Physicians' Relation | nt program so they could be so could be taken to prevent a 34-year-old female who was spital on 11/09/09 for sulcide attempt. Scharge summary note, dated M, stated that "While in the ment (11/09/09), the patient gle herself with IV (intervenous) currence Report could not be ent. This was confirmed during 17/10 starting at 4:36 PM, with ctor of Risk Management and ons. | A | 267 | | | | |
| | propositioned" by a Risk Occurrence Fincident. It did not and resolution of the confirmed during a at 4:36 PM, with the Management and stated the Risk Occurrenced events related to Fincially improvement analyzed and step further incidents. 5. Patient #2 was a admitted to the hospital falled. | another female patient. The Report only contained the contain a review, investigation he incident. This was in interview on 1/27/10 starting he Executive Director of Risk Physicians' Relations where he currence Report was to ensure that all adverse Patient #5 were reported to the nt program so they could be social be taken to prevent a 14-year-old male who was spital on 11/06/09 for bipolar latric Technician Note, dated | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XGKZ11

Facility ID: IDLFQV

If continuation sheet Page 6 of 7

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P. 10

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FÓRN | 1 APPROVED 1, 0938-0391 | |
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| | staff member twice Techniclan Note, da stated that Patient is another staff member 11/08/09 at 5:28 PM picked up a long was a staff member with wood piece from Patient #2 was rest 11:45 AM. The RN Patient #2 complain he sustained an injuration of Risk Ma Relations was inter Risk Occurrence R with Patient #2. He been filled out for e The hospital failed events related to Pi quality improvement | A, stated Patjent #2 punched a A second Psychiatric ated 11/08/09 at 12:15 AM, #2 punched and kicked er. A nursing note dated A, stated Patient #2 had coden piece to a game and hit it and when staff took the atient #2, he hit the staff and chest and kicked them, rained on 11/08/09 starting at restraint checklist stated that hed that his back hurt because ury during the restraint at 4:36 PM, the Executive nagement and Physicians' viewed. He could not find the eports for the above incidents e stated that one should have | A | 267 | | | | |

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FORM APPROVED Bureau of Facility Standards (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING B. WING 01/29/2010 130018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3100 CHANNING WAY EASTERN IDAHO REGIONAL MEDICAL CENTE IDAHO FALLS, ID 83404 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (X4) 1D COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAĠ DEFICIENCY) With regards to item BB124, B 000 8 000 16.03.14 Initial Comments the following plan will be implemented in addition to The following deficiencies were cited during the the action plan for item complaint investigation of your hospital. The surveyors conducting the survey were: A267: The review of occurrence reports Patrick Hendrickson, RN, Team Leader will occur at least once per Aimee Hastriter, RN, HFS month. This will include a review of the occurrences for BB124 BB124 16.03.14.200.10 Quality Assurance that month along with analysis of the accumulative data and 10. Quality Assurance, Through administration potential long-term trends. and medical staff, the governing body shall ensure that there is an effective, hospital-wide The quality improvementfor quality assurance program to evaluate the BHC plan will include developing provision of care. The hospital must take and a written plan of correction document appropriate remedial action to address for each identified trend. deficiencies found through the program. The These plans will be reviewed hospital must document the outcome of the remedial action. (10-14-88) by the management team bimonthly until they are resolved. This Rule is not met as evidenced by: Refer to A267 as it relates to the hospital's failare to ensure that all adverse patient events were reported to the quality improvement program so they could be analyzed and steps could be taken to prevent further incidents. Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE 3/3/10

(X6) DATE

STATE FORM

00

XGKZ11

If continuation sheet 1 of 1

C.L. "BUTCH" OTTER – Governor RICHARD M. ARMSTRONG – Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-D036 PHONE 208-334-6626 FAX 208-364-1888

February 4, 2010

Doug Crabtree Eastern Idaho Regional Medical Center P.O. Box 2077 Idaho Falls, ID 83403-2077

Provider #130018

Dear Mr. Crabtree:

On January 29, 2010, a complaint survey was conducted at Eastern Idaho Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004491

Allegation: A patient successfully committed suicide while he was admitted in the hospital's psychiatric unit. The hospital failed to keep the patient safe from himself.

Findings: An unannounced visit was made to the hospital on 1/26/10 through 1/29/10. Hospital policies, incident reports, a root-cause-analysis report, a police report and seven patient records were reviewed. Patients and hospital staff were interviewed.

One record documented a young adult male who was admitted to the hospital on 1/13/10 for treatment of suicidal ideation and depression. A Psychiatric Technician Note, dated 1/13/10 at 3:30 PM, stated the patient did not appear to be depressed and was on the unit laughing and joking.

A Psychiatric Evaluation, dated 1/14/10 at 10:22 PM, stated the patient was suicidal following a rejection by his girlfriend. The psychiatrist documented that he did think the patient was a risk for suicide. The patient's Plan of Care, dated 1/13/10, stated staff were to monitor the patient for depression and check on the patient's safety every 15 minutes. The checks were documented as completed throughout the patient's stay.

Doug Crabtree February 4, 2010 Page 2 of 3

Nursing and technician notes dated 1/14 to 1/15/10 stated the patient was aggressive, verbally abusive and physically violent to staff and other patients and on 1/15/10 the patient was placed on "level 4." A level 4 meant the patient was restricted to the unit, his room was searched each day, and he was not allowed visitors.

On 1/16/10 at 3:15 PM, a nurse documented the patient tried to remove some tubing off a blood pressure machine and take it back into his room. An incident report could not be found for the above event. On 1/26/10 starting at 4:00 PM, during a Risk Management Meeting, this incident was discussed. The Behavioral Health Center's Executive Director stated he and the physician were notified of the incident. The Executive Director stated the physician did not order one to one staff for the patient because he felt that would escalate the patient's aggressive and violent behaviors.

A Psychiatric Technician Note, dated 1/17/10 at 1:30 PM, stated the patient never voiced a desire to commit suicide and expressed a desire to go to jail verses going to a state psychiatric hospital.

A Patient Observation Record, dated 1/18/10, stated the patient was observed in his room sleeping from 12:00 AM to 12:30 AM.

A Psychiatric Technician and Registered Nurse who worked the morning of 1/18/10 were interviewed on 1/26/10 starting at 5:30 PM. They both stated the patient was found in his room hanging from a door with a bed sheet on 1/18/10 at around 12:50 AM. They stated the patient was transferred to the hospital's Emergency Department (ED) where he was pronounced dead. This was at 1:43 AM, according to the ED record. The Psychiatric Technician and Registered Nurse stated another patient on the unit was having a seizure during the time of the hanging. They stated a physician and another nurse were on the unit during that time also to help with cares. The Psychiatric Technician stated that when he went to check the patients at 12:45 AM, he found the patient hanging by a bed sheet around 12:50 AM. This was consistent with a police report dated 1/18/10 at 1:30 AM.

Based on the investigative findings, the hospital made reasonable efforts to keep the patient safe from himself. However, a deficiency was cited at 42 CFR 482.21 (a)(2) for failure of the hospital to ensure the Performance Improvement Program had analyzed all patient adverse events and injuries.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

Doug Crabtree February 4, 2010 Page 3 of 3

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

PATRICK HENDRICKSON Health Facility Surveyor

Non-Long Term Care

SYLVIA CRESWELL

Co-Supervisor

Non-Long Term Care

PH/mlw